

CLIENT ASSESSMENT FORM

Name: _____

Address: _____

Phone: C _____ H _____

W _____ Email _____

Employer: _____ Insurance: _____

Member Name and ID# _____

Group# _____ Age/DOB: ____ / _____

Mental Health/Substance Abuse # (on back of insurance card)

Marital Status: _____

Number of Children and Ages: _____

Reason for contacting me: _____

Past counseling: _____

Medical Problems: _____

Financial/Legal Problems: _____

SUBSTANCE USE

Over-the-Counter drugs (Dose and Times a day):

Prescription Drugs (Dose and Times a day):

RISK ASSESSMENT

- Suicidal Thoughts _____
- Suicidal Action _____
- Verbal / Physical Aggression _____
- Substance Abuse _____
- Substance Abuse Treatment _____

WORK HISTORY

ASSESSED PROBLEMS

- 1) _____
- 2) _____
- 3) _____

GENOGRAM / CLINICAL NOTES